

**Self-Injury and Eating Disorders in Minors:
When Should the Human Service Professional Break Confidentiality?**

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Abstract

The decision to protect or breach confidentiality is a common ethical dilemma for human service professionals. This decision is further complicated when the client is a child or adolescent. This manuscript examines the issue of confidentiality and minors with two common harmful behaviors in adolescents: self-injury and eating disorders. A continuum of physical and psychological factors are included to help the human service profession in ethical decision making. Two case studies followed by a list of questions to use in the decision making process are also provided.

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Human service professionals are responsible to learn, understand, and uphold the ethics of the profession (Milliken & Neukrug, 2009; Neukrug, 2013). The NOHS Code of Ethics provides standards for the human service professional's responsibility to clients, community and society, colleagues, the profession, employers, the self, and the human service educator (Wark, 2010). While the NOHS Ethical Standards serve as a useful guide for practitioners, it is important to recognize that the current ethical standards are now more than 15 years old. Thus, issues that emerged in recent years as relevant to the human service professional may not be included (Neukrug & Milliken, 2009).

Ethical decision making is a critical skill for the human service professional (Corey, Corey, & Callanan, 2011). Keeping client information confidential is a critical ingredient in the client-helper

relationship (Neukrug, 2013). However, when one's client is a minor, the issues of confidentiality become even more complex (Isaacs & Stone, 2001). The responsibility to protect client confidentiality is as great as the enormity of breaching confidentiality. Making the decision whether or not to breach confidentiality should not be an easy one; it should cause the human service professional great discomfort (Lavosky, 2008).

While there is no specific ethical decision making guide for human service professionals, researchers in the related fields of social work and counseling have developed ethical decision making tools to assist practitioners in making ethical decisions. For example, Dolgoff, Loewenberg, and Harrington (2005) developed the Ethical Principles Screen. This screening tool is prominent in the field of social work and includes seven principles to consider prior to making an ethical decision. The first principle starts with the protection of life and also considers the principles of Equality and Inequality, Autonomy and Freedom, Least Harm, Quality of Life, Privacy and Confidentiality and Truthfulness and Full Disclosure. Additionally, The Ethical Decision Making Model designed by Corey, et al. (2011) is a commonly used model in the counseling field. This model relies largely on personal values and how the professionals value effect the client. Similar to the Ethical Principles Screen, the model by Corey, et al. (2011) also includes seven steps to consider prior to making an ethical decision. These steps are to (1) Identify the problem; (2) Identify the potential issues involved; (3) Review the relevant ethical guidelines; (4) Know the relevant laws and regulations; (5) Obtain consultation; (6) Consider possible and probable courses of action; (7) List the consequences of the probable courses of action.

A shared commonality in the above models that will be explored in this paper is confidentiality, a critical agreement between the client and the human service professional (Neukrug, 2013). Thus, it is not surprising that the human service professional routinely encounters ethical dilemmas surrounding confidentiality. The issue of confidentiality can be found within the human service professional's responsibility to clients, specifically in Statement 3 and Statement 4 (National Organization of Human Services, 1996):

Statement 3: Human service professionals protect the client's right to privacy and confidentiality except when such confidentiality would cause harm to the client or others, when agency guidelines state otherwise, or under other stated conditions (e.g., local, state, or federal laws). Professionals inform clients of the limits of confidentiality prior to the onset of the helping relationship.

Statement 4: If it is suspected that danger or harm may occur to the client or to others as a result of a client's behavior, the human service professional acts in an appropriate and professional manner to protect the safety of those individuals. This may involve seeking consultation, supervision, and/or breaking the confidentiality of the relationship.

As seen above, both Statement 3 and Statement 4 assert that suspected harm to the client is a reason for breaching confidentiality. However, the statements above leave us with many questions. For example: What exactly is harm or suspected danger to client? What does it mean to act in an appropriate and professional manner to protect the safety of those individuals? Finally, what does it mean if one's client is a minor? In order to look closely at issues of confidentiality in minors, we will examine two increasingly common behaviors in adolescents: self-injury and eating disorders.

Protecting the Client

Without argument, both eating disordered behaviors and self-injury cause harm to the client. However, does that harm constitute enough danger to break confidentiality? Breaching confidentiality does not have to be a clearly delineated issue (Isaacs & Stone, 2001). Rather, breaching can fall on a continuum from not breaking confidentiality to contacting the parents immediately without consent of the child. The least intrusive approach to breaching may involve encouraging the client to tell her or his parents/guardians, allowing her or him the opportunity of calling their parents/guardians (with or without the helping professional's assistance). The most intrusive approach would be to call parents/guardians without

alerting the clients to this. Depending on the severity of the situation, each action along the continuum may be appropriate at times (Stone, 2005). However, in the end, this decision is not easy and should follow Statement 4 guidelines of seeking consultation and supervision prior to making a decision (National Organization of Human Services, 1996).

Who is the Client?

Statement 2 in the NOHS ethical standards states, “Human service professionals respect the integrity and welfare of the client at all times. Each client is treated with respect, acceptance and dignity” (National Organization of Human Services, 1996). Further, Statement 3 states that “human service professionals protect the client’s right to privacy and confidentiality” (National Organization of Human Services, 1996). However, when the client is a minor, what is the human service professional’s responsibility to the parent or legal guardian? The research is unclear about parents or guardians’ legal rights to access information shared by their child in the helping relationship (Ritchie and Huss, 2000). While parental rights generally override those of the minor, state laws do not provide clear guidelines on these rights (Bodenhorn, 2006; Isaacs & Stone, 2001). For example, laws in 20 states including the District of Columbia give minors the explicit authority to consent to outpatient mental health services (“Guttmacher Report on Public Policy,” 2002). Specifically, in the state of Michigan, adolescents who are 14 years old or older can authorize their own mental health services (“The Michigan Bar,” n.d.). Therefore, while there are differences in laws across states regarding parental rights, there is some consensus among researchers in the field that ethically the child is the client but legally the parent/guardians is the client (Remley & Herlihy, 2001; Froeshcle & Moyer, 2004; Ritchie & Norris Huss, 2000). Similarly, Remley and Herlihy (2001) explain that students may have an ethical right to confidentiality while also noting that parents/guardians have a legal right to their child's privacy.

Breaching Confidentiality

It is important to be aware of the consequences of breaching confidentiality. Completely breaching confidentiality could place the

human service professional in a position of breaking the law in her or his state (Isaacs, 2001). Further, if complete confidentiality is protected, families might later bring a legal suit against the human service professional or agency claiming they had knowledge that might have helped the family prevent harm (Stone, 2005). Clearly, it is a difficult task to balance the minor client’s rights with the legal and ethical rights of the parent or guardian (White Kress, Drouhard, & Costin, 2006). Once again, as recommended by the NOHS Ethical guidelines, supervision and consultation are necessary in these situations (Glosoff & Pate, 2002).

Identifying Harmful Behaviors

If a human service professional suspects that a client is engaging in self-injurious or disordered eating behaviors, she or he must decide if it is necessary to break the client’s confidentiality (Mitchell, Disque, & Robertson, 2002). According to Statement 3, this confidentiality should be broken only when it is suspected that “harm or danger may occur to the client...as a result of the client’s behavior” (National Organization of Human Services, 1996). The following sections explain which aspects of self-injury and disordered eating may qualify as physical and psychological “harm” so that the human service professional might recognize these symptoms and therefore act to “protect the safety of these individuals” (National Organization of Human Services, 1996). While there is no standard equation to determine when to break confidentiality using the continuum of symptoms, this continuum might serve as a guide for human service professionals to help make the difficult, yet crucial decision on whether or not to breach confidentiality.

Self-Injurious Behavior

Self-injurious behaviors can signify both physical and psychological harm for the client. Physically harmful behaviors, first of all, can be seen on a continuum from less severe behaviors, which result in artificial wounds, to moderately severe behaviors, where the skin is broken, to severe behaviors, which may result in drastic health consequences, like infection and even death (see Table 1). Less severe behaviors, first of all, do not incur serious bodily harm. Examples of these

Table 1: Self-Injury Continuum of Behaviors

	Less Severe	Moderately Severe	Severe
Physical Harm	Scratching	Cutting	Burning
	Skin Picking	Rubbing	Cutting with Large Objects
	Biting		Severing
	Pinching		Eye Enucleation
Psychological Harm	Low Self-esteem	Depression	Desperation
	Anxiety	Crippling Anxiety	Revenge
	Inability to Cope	Impulsivity	Wanting to Punish
			Suicidal Ideation

behaviors, which may not be noticeable to the naked eye, include scratching oneself and picking one’s skin (Simpson, Armstrong, Couch, & Bore, 2010). The adolescent may also engage in minor biting that does not break the skin (Alfonso & Dedrick, 2010) and pinching herself or himself (Ross & Health, 2002).

Moving along on the continuum, moderately severe self-injurious behaviors may leave scars on the client’s arms, thighs, or other places of infliction. These behaviors include cutting oneself with sharp objects such as paperclips or thumbtacks. Adolescents may also use pencil erasers to leave permanent marks on their arms or legs (Simpson, Armstrong, Couch, & Bore, 2010). The most severe self-injurious behaviors can cause serious bodily harm. These behaviors include burning (Alfonso & Dedrick, 2010), hitting (Toste & Heath, 2010), and cutting oneself with large, sharper objects such as a razor blade (Simpson, Armstrong, Couch, & Bore, 2010). The client may also attempt to sever a limb (Alfonso & Dedrick, 2010) or even enucleate an eye (Suresh Kumar, Subramanian, Kunhi Koyamu, & Kumar, 2001).

In addition to falling under the category of physical harm, self-injury signals psychological harm to the client as well (Craigén & Foster, 2009). This psychological harm can be categorized on the same continuum as physical harm: less severe, moderately severe, and severe. Less severe psychological harm may include feelings of low self-esteem, mild anxiety, and an inability to cope with a stressful life event, but does not significantly interfere with daily living (Madge, et al. 2011).

Moderately severe psychological harm includes feelings of depression and anxiety (Ross, & Heath, 2002). The client may also show signs of impulsivity that may prove to be dangerous (Madge, et al., 2011). Severe psychological harm that coincides with self-injury may include feelings of desperation, revenge, wanting to punish oneself or others, and suicidal thoughts (Scoliers, et al. 2009).

Eating Disorders

Similar to self-injurious behaviors, symptoms of eating disorders can qualify as both physical and psychological harm to the client. Disordered eating that affects the physical wellbeing of the client can be seen on a continuum of less severe, problematic behaviors, to moderately severe behaviors which impact one’s health (see Table 2). The severe symptoms of eating disorders signify extreme medical conditions as a result of the disorder (National Institute of Mental Health, 2012).

Less severe behaviors include the adolescent’s desire to diet and lose weight. This desire may evolve into moderately severe behaviors, which then would impact the client’s health. These behaviors include a refusal to maintain body weight at or above an average weight for her or his height (National Eating Disorders Organization, 2012). Other moderately severe behaviors include engaging in substance abuse such as the use of diet pills (Eichen, Conner, Daly, & Fauber, 2012). The client might also fast, refuse to eat regular meals, and/or avoid eating with others (Giles & Hass, 2008).

These moderately severe disordered eating behaviors may evolve into severe physical symptoms such as brittle hair and nails, lethargy, dry and yellowish skin, extreme thinness, severe hydration, intestinal distress,

Table 2: Eating Disorder Continuum of Behaviors

	Less Severe	Moderately Severe	Severe
Physical Harm	Dieting	Refusal to Maintain Body Weight	Brittle Hair and Nails
	Desire to Lose Weight	Substance Abuse	Lethargy
		Fasting	Dry and Yellowish Skin
		Avoiding Eating with Others	Extreme Thinness
			Severe Hydration
			Intestinal Distress
			Feeling Cold
			Lack of Menstrual Cycle
			Organ Failure
			Death
Psychological Harm	Dissatisfaction with Outward Appearance	Distorted Body Image	Loss of Control
	Helplessness	Fear of Being Overweight	Overwhelming Fear of Gaining Weight
			Extreme Concern with Body Shape

feeling constantly cold, and lack of menstrual cycle (National Institute of Mental Health, 2012). The client may be at risk for heart failure, brain failure, or even death (American Academy of Child and Adolescent Psychiatry, 2012).

Human service professionals should likewise be aware of the psychological harm associated with disordered eating. Similar to self-injury, this type of harm might be viewed on a continuum of less severe to moderately severe to severe. Less severe symptoms include dissatisfaction with one’s outward appearance as well as inward feelings of helplessness (American Psychological Association, 2012). Moderately severe symptoms include a distorted body image (National Institute of Mental

Health, 2012) as well as an irrational fear of appearing to be overweight (National Eating Disorders Organization, 2012).

Severe psychological behaviors include the adolescent's sense of a loss of control (American Academy of Child and Adolescent Psychiatry, 2012) accompanied by an overwhelming fear of gaining weight (National Institute of Mental Health, 2012). This extreme concern with one's body shape may hinder the adolescent's daily functioning and destroy his or her sense of self (American Psychological Association, 2012). The adolescent may spend extensive time examining his or her body in the mirror or weighing him or herself excessively (Gass & Hass, 2008).

Application

Undoubtedly, human service professionals will encounter the dilemma of when to break confidentiality with clients (Isaacs & Stone, 2001; Neukrug, 2013). This section includes fictitious case studies, representing situations that many human service professionals will encounter. The two cases below may prove challenging to the human service professional because they present both legal and ethical dilemmas. After each case study we will provide you with questions to consider that will assist you in making an informed and ethically responsible decision. At the conclusion of each case, a case summary discussion is provided.

Case 1: Amber

You are running an anger management group for adolescent women at your community services board. After the third session, you notice that one of the group members, Amber, appears to be more withdrawn and isolated. When the group concludes you ask to speak to Amber. As you are talking to her, you notice that she quickly pulls down her long-sleeved shirt to cover her arms. You ask her about this and she slowly rolls up her sleeves, revealing a series of cuts. You look more closely to see that many of the wounds are in the beginning of healing process and are beginning to scab over. Immediately, Amber states, "I cut myself. I have been cutting myself with a razor blade for the last few weeks. My boyfriend broke up with me, my parents are fighting all the

time, and I am failing my classes. This is the only thing that I have that makes me feel better. I don't know what I would do if I couldn't cut myself'

Given this encounter with Amber, the following questions are provided to help guide you in your ethical decision making:

1. Given the continuum of physical risk factors, are Amber's wounds dangerous? In other words, do they require medical care? Does she appear to be cutting near major arteries?
2. Given the continuum of psychological risk factors, does Amber present with additional psychological symptoms that put her in a position of danger? (Does she seemed detached or is she grounded in reality?)
3. Given a full suicide assessment, did Amber cut herself in an attempt to end her life? Or, did the self-injury serve as a maladaptive coping strategy?
4. What is your agency's stance on reporting self-injury? Did you communicate this stance with Amber?
5. What does your state law say about confidentiality and minors?
6. What are the potential consequences of reporting Amber's self-injury to her parents? What are the potential consequences of NOT reporting Amber's self-injury to her parents?
7. Who will you consult with to discuss Amber's case?

Case Summary:

The questions following the case study serve as a practical guide to assist human service professionals with the ethical decision making process. In Amber's case, questions #4-5 are a bit more prescriptive in that the answers are dictated by agency policy or state law. Also, the final two questions (#6-7) are related to weighing all of your responses together while gaining both supervision and consultation. Thus, this summary will focus on the first three questions.

The first three questions are related to the level of danger with respect to the physical and psychological symptoms in addition to the risk for suicide. As discussed previously, there is a great deal of ambiguity with respect to assessing the level of danger with self-injury. In the case of

Amber, it is important to focus on three main areas: her behavior, her physical presentation, and her verbal statements. Amber's increasing isolative behavior and her observable physical wounds are strong and potentially dangerous indicators that may compel the human service professional to break confidentiality. Further, her verbal statement, "This is the only thing that makes me feel better. I don't know what I would do if I couldn't cut myself" is cause for concern. In isolation, this statement does not indicate that Amber is at risk to commit suicide. However, it is the responsibility of the human service professional to ask Amber to expand on this statement and to conduct a comprehensive suicide assessment to determine if Amber's act of self-injury was indeed an attempt to end her life. Further, if her responses indicate a risk for suicide it is the human professional's obligation to breach confidentiality to protect Amber's well-being.

Case 2: Fredelito

You are a behavioral support counselor at a local high school. Fredelito, age 17, is referred to your office for defiance in his classroom. His teacher had Fredelito last year and she stated to you, "He is a different student this year. Last year, he was cooperative, kind, and polite, but this year, he is argumentative, hostile, and aggressive with his peers." You have been meeting with Fredelito for the past four weeks. He is beginning to open up to you and talk to you about his struggles. He shares with you that he has always struggled with his weight and hates looking at himself in the mirror. Fredelito remarks that he would like to lose more weight but his mother always is making him eat. For the past six months, he shares that he has been purging nearly everything that he eats. He estimates that he makes himself vomit three to four times a day. He shares that what started as something that he did infrequently he now feels like, "I have to do it and if I don't, I feel so gross inside and the guilt is too much to take." As Fredelito shares this with you, the physical observations that you have made in the past are all starting to come together. Fredelito has a noticeable yellowing of his teeth and complains of consistent stomach pain. Given this encounter with Fredelito, the following questions are provided to help guide you in your ethical decision making:

1. Given the continuum of physical risk factors, are Fredelito's symptoms dangerous? In other words, should he seek medical care?
2. Given the continuum of psychological risk factors, does Fredelito present with additional psychological symptoms that put him in a position of danger? (Does he seem detached or is he grounded in reality?)
3. Based on your discussion with Fredelito, do you feel that he is at risk for suicide?
4. What is your agency's stance on reporting issues similar to this with minors? Did you communicate this stance with Fredelito?
5. What does your state law say about confidentiality and minors?
6. What are the potential consequences of reporting Fredelito's eating disordered behaviors to his parents? What are the potential consequences of NOT reporting Fredelito's eating disordered behaviors to his parents?
7. Who will you consult with to discuss Fredelito's case?

Case Summary

In the case of Fredelito, the line of questioning is almost identical to Amber's case. Thus, similarly to the case summary above, this case summary will focus on the first three questions related to his physical and psychological risk factors as well as the potential risk for suicide. As with Amber, it is important to focus on three main areas with Fredelito: his behavior, his physical presentation, and his verbal statements. With respect to his behavior, Fredelito is demonstrating a recent change in this behavior. He went from a cooperative and kind student to defiant and aggressive towards his peers. With respect to his physical symptoms, Fredelito is beginning to manifest physical consequences of his eating disorder: the yellowing of his teeth and his consistent stomach pains. Further, in conversation, Fredelito shares, "...the guilt is too much to take." While this statement alone does not indicate suicidality, it is important to learn more about what Fredelito means by this statement and if there is concern, to conduct a comprehensive suicide assessment. In the case of Fredelito, the drastic change in behavior coupled with his emerging physical symptoms and verbal statements are certainly rise for

concern and may necessitate the need for the human service professional to breach confidentiality.

Summary

A human service professional will routinely encounter the ethical dilemmas like the ones described in this article. While answering these questions is not easy, it is an essential step to take in determining whether to break a child or adolescent client's confidentiality. Both the NOHS Code of Ethics and the continuum of physical and psychological symptoms that the authors provided serve as a guide to assist the human service professional in ethical decision making. Finally, it is important to remember that decisions should never be made in isolation; supervision and consultation with colleagues is an essential step in the ethical decision making process (National Organization of Human Services, 1996; Neukrug, 2013).

While supervision and consultation are critical components of ethical decision making, human service professionals can also position themselves to become better informed about dilemmas that they will likely encounter when working with children and adolescents. Thus, it would behoove the human service professional to seek out additional trainings and continuing education opportunities on ethical decision making. Further, because of the lack of uniformity in the law across states, it will be critical for professionals to familiarize themselves with state guidelines on parental rights and to acquaint themselves with their own agency's stance on confidentiality with minors, especially related to self-injury and eating disorders.

Additionally, both NOHS and The Council for Standards in Human Service Education (CSHSE) can also serve as a great resource for human service professionals as well as human service educators on the topics of ethical decision making. The *Journal of Human Services* and the quarterly newsletter, *The Link* routinely feature articles on ethics and ethical decision making. Additionally, The Council for Standards in Human Service Education (CSHSE) has outlined required national standards related to ethics for all Associate, Baccalaureate, and Master's Level degree programs. These standards are available to the public

through the CSHSE website. Finally, while these resources are available, it is ultimately up to the human service professional to seek these opportunities out in the future.

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